EXHIBIT C

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Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to Public Inspection

Part I Annual Report Identification Information
For the calendar plan year 2008 or fiscal plan year beginning May 01, 2008 , and ending April 30, 2009

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information – enter all requested information.

1a Name of plan
BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 2 ALBANY, NY ANNUITY FUND

1b Three-digit plan number (PN) 002
1c Effective date of plan (mo., day, yr.) July 01, 1987

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 2 ALBANY, NY ANNUITY FUND
300 CENTRE DRIVE
ALBANY NY 12203-4474

2b Employer Identification Number (EIN) 16-1298070
2c Sponsor's telephone number 518-456-0259
2d Business code (see instructions) 813930

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

	11/26/1202	STEVEN J OSICK, PLAN ADMINISTRATOR
Signature of plan administrator	Date	Typed or printed name of individual signing as plan administrator
		BRICKLAYERS & ALLIED CRAFTWORKERS
Signature of employer/plan sponsor/DFE	Date	Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.
v11.3
Form **5500** (2008)

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
SA14H

3b Administrator's EIN
3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
a Sponsor's name
b EIN
c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address		**b** EIN 14-1624930
TRAL, BECKKK & CHIARAM014TE CPAS PC 7 WAAHINGTON SQUARLR AT-BANY 12205		**c** Telephone no. 518-456-6663
6 Total number of participants at the beginning of the plan year	**6**	1263
7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a Active participants	**a**	1455
b Retired or separated participants receiving benefits	**b**	49
c Other retired or separated participants entitled to future benefits	**c**	
d Subtotal. Add lines **7a, 7b,** and **7c**	**d**	1504
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	11
f Total. Add lines **7d** and **7e**	**f**	1515
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	1515
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

2C 3B

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☒ **R** (Retirement Plan Information)
- **(2)** ☐ **T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☐ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☐ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☒ 1 **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☒ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

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Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	**Annual Return/Report of Employee Benefit Plan** **This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).** **Complete all entries in accordance with the instructions to the Form 5500.**	Official Use Only OMB Nos. 1210 - 0110 1210 - 0089 **2008** **This Form is Open to Public Inspection**

Part I Annual Report Identification Information
For the calendar plan year 2008 or fiscal plan year beginning May 01, 2008 , and ending April 30, 2009

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information – enter all requested information.

1a Name of plan
BRICKLAYERS & ALLIED CRAFTWORKERS L ALBANY, NY HEALTH BENEFIT FUND

1b Three-digit plan number (PN) 501

1c Effective date of plan (mo., day, yr.) November 15, 1962

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
BRICKLAYERS & ALLIED CRAFTWORKERS L2 ALBANY, NY HEALTH BENEFIT FUND
300 CENTRE DRIVE
ALBANY NY 12203-4474

2b Employer Identification Number (EIN) 14-1461803

2c Sponsor's telephone number 518-456-0259

2d Business code (see instructions) 813930

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	Date	STEPHEN OSICK, PLAN ADMINISTRATOR Typed or printed name of individual signing as plan administrator
Signature of employer/plan sponsor/DFE	Date	BRICKLAYERS & ALLIED CRAFTWORKERS Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form **5500** (2008)
v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
SAME

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

TEAL, BECKER & CHIARAMONTE CPAS PC
7 WASHINGTON SQUARE
ALBANY NY 12205

b EIN 14-1624930

c Telephone no. 518-456-6663

6 Total number of participants at the beginning of the plan year	**6**	666
7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a Active participants	**a**	664
b Retired or separated participants receiving benefits	**b**	18
c Other retired or separated participants entitled to future benefits	**c**	
d Subtotal. Add lines **7a, 7b,** and **7c**	**d**	682
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	
f Total. Add lines **7d** and **7e**	**f**	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☐ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

b ☒ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

4A 4B 4C 4D 4E 4F 4Q

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☐ **R** (Retirement Plan Information)
- **(2)** ☐ **0T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☐ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☐ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☒ 10 **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☐ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

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Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
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Part I Annual Report Identification Information
For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008 , and ending June 30, 2009

A This return/report is for:
(1) ☐ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☒ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☐

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information – enter all requested information.

1a Name of plan
BUILDING TRADES EMPLOYERS INSURANCE FUND HEALTH PL

1b Three-digit plan number (PN) 501
1c Effective date of plan (mo., day, yr.) July 01, 1965

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
BUILDING TRADES EMPLOYERS INSURANCE
6563 RIDINGS ROAD
SYRACUSE NY 13206-1202

2b Employer Identification Number (EIN) 22-3089633
2c Sponsor's telephone number 315-437-9284
2d Business code (see instructions) 525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	Date	EARL N. HALL Typed or printed name of individual signing as plan administrator
Signature of employer/plan sponsor/DFE	Date	EARL N. HALL Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form **5500** (2008)
v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
SAME

3b Administrator's EIN
3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
a Sponsor's name
b EIN
c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

J BRADFORD MANN
7030 E GENESEE STREET
FAYETTEVILLE 13066-1126

b EIN 16-1143867
c Telephone no. 315-446-5745

6 Total number of participants at the beginning of the plan year	**6**	946
7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a Active participants	**a**	1575
b Retired or separated participants receiving benefits	**b**	34
c Other retired or separated participants entitled to future benefits	**c**	
d Subtotal. Add lines **7a, 7b,** and **7c**	**d**	1609
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	
f Total. Add lines **7d** and **7e**	**f**	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☐ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

b ☒ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

4A 4B

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☐ **R** (Retirement Plan Information)
- **(2)** ☐ **T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☐ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☐ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☒ **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☐ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

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Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
Complete all entries in accordance with the instructions to the Form 5500.

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For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008 , and ending June 30, 2009

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☐

Part II Basic Plan Information – enter all requested information.

1a Name of plan
ONONDAGA COUNTY LABORERS ANNUITY FUND

1b Three-digit plan number (PN) 002
1c Effective date of plan (mo., day, yr.) April 01, 1984

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
ONONDAGA COUNTY LABORERS ANNUITY FUND BOARD OF TRUSTEES
7051 FLY ROAD
EAST SYRACUSE NY 13057-9659

2b Employer Identification Number (EIN) 16-1229376
2c Sponsor's telephone number 315-434-9305
2d Business code (see instructions) 525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	Date	GABRIEL ROSETTI, III Typed or printed name of individual signing as plan administrator
Signature of employer/plan sponsor/DFE	Date	EARL R. HALL Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form **5500** (2008)
v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
SAME

3b Administrator's EIN
3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
a Sponsor's name
b EIN
c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address		**b** EIN 16-1537589
RICHARD W. HEIMERMAN, CPA P.C. 290 ELWOOD DAVIS ROAD, SUITE 280 LIVERPOOL NY 13088-0000		**c** Telephone no. 315-451-9771
6 Total number of participants at the beginning of the plan year	**6**	492
7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a Active participants	**a**	529
b Retired or separated participants receiving benefits	**b**	19
c Other retired or separated participants entitled to future benefits	**c**	285
d Subtotal. Add lines **7a, 7b,** and **7c**	**d**	833
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	19
f Total. Add lines **7d** and **7e**	**f**	852
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	852
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	17

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

2E

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☐ **R** (Retirement Plan Information)
- **(2)** ☐ **T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☐ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☒ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☒ 1 **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☒ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

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Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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Complete all entries in accordance with the instructions to the Form 5500.

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(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information – enter all requested information.

1a Name of plan
CENTRAL NEW YORK LABORERS WELFARE FUND

1b Three-digit plan number (PN) 501
1c Effective date of plan (mo., day, yr.) May 21, 1953

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
CENTRAL NEW YORK LABORERS WELFARE FUND BOARD OF TRUSTEES
7051 FLY ROAD
EAST SYRACUSE NY 13057-9659

2b Employer Identification Number (EIN) 16-6044095
2c Sponsor's telephone number 315-434-9305
2d Business code (see instructions) 525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	Date	GABRIEL ROSETTI, III Typed or printed name of individual signing as plan administrator
Signature of employer/plan sponsor/DFE	Date	EARL R. HALL Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form **5500** (2008)
v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
SAME

3b Administrator's EIN
3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
a Sponsor's name
b EIN
c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address		**b** EIN 16-1537589
RICHARD W. HEIMERMAN, CPA P.C. 290 ELWOOD DAVIS ROAD, SUITE 280 LIVERPOOL NY 13088-0000		**c** Telephone no. 315-451-9771
6 Total number of participants at the beginning of the plan year	**6**	635
7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a Active participants	**a**	288
b Retired or separated participants receiving benefits	**b**	250
c Other retired or separated participants entitled to future benefits	**c**	173
d Subtotal. Add lines **7a, 7b,** and **7c**	**d**	711
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	
f Total. Add lines **7d** and **7e**	**f**	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☐ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

b ☒ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

4A 4D 4E 4F 4L

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☐ **R** (Retirement Plan Information)
- **(2)** ☐ **T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☐ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☐ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☒ 1 **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☐ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

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Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to Public Inspection

Part I Annual Report Identification Information
For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008 , and ending June 30, 2009

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information – enter all requested information.

1a Name of plan
CENTRAL NEW YORK LABORERS PENSION FUND

1b Three-digit plan number (PN) 001
1c Effective date of plan (mo., day, yr.) January 05, 1960

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
CENTRAL NEW YORK LABORERS PENSION FUND BOARD OF TRUSTEES
7051 FLY ROAD
EAST SYRACUSE NY 13057-9659

2b Employer Identification Number (EIN) 15-6016579
2c Sponsor's telephone number 315-434-9305
2d Business code (see instructions) 525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	Date	GABRIEL M. ROSETTI, III Typed or printed name of individual signing as plan administrator
Signature of employer/plan sponsor/DFE	Date	EARL R. HALL Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form **5500** (2008)
v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
SAME

3b Administrator's EIN
3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
a Sponsor's name
b EIN
c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

RICHARD W. HEIMERMAN, CPA P.C.
290 ELWOOD DAVIS ROAD, SUITE 280
LIVERPOOL NY 13088-0000

b EIN 16-1537589
c Telephone no. 315-451-9771

6 Total number of participants at the beginning of the plan year	**6**	677
7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a Active participants	**a**	219
b Retired or separated participants receiving benefits	**b**	281
c Other retired or separated participants entitled to future benefits	**c**	100
d Subtotal. Add lines **7a, 7b,** and **7c**	**d**	600
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	74
f Total. Add lines **7d** and **7e**	**f**	674
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	7

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

1B 1G

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☒ **R** (Retirement Plan Information)
- **(2)** ☐ **T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☒ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☒ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☐ **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☒ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to Public Inspection

Part I Annual Report Identification Information
For the calendar plan year 2008 or fiscal plan year beginning April 01, 2008 , and ending March 31, 2009

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☐

Part II Basic Plan Information – enter all requested information.

1a Name of plan
ENGINEERS JOINT WELFARE FUND LOCAL UNIONS 17,106,410,463,545,832

1b Three-digit plan number (PN) 501
1c Effective date of plan (mo., day, yr.) January 05, 1957

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
BD OF TRUSTEES ENG JT WELF FD LCL UNIONS 17,106,410,463,545,832 IUOE
PO BOX 100 COLVIN STA
SYRACUSE NY 13205-0100

2b Employer Identification Number (EIN) 15-0582931
2c Sponsor's telephone number 315-492-1796
2d Business code (see instructions) 525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

	01/01/2210	THERON HOQLE
Signature of plan administrator	Date	Typed or printed name of individual signing as plan administrator
	11/01/2210	EUQENE P. HALLOCK
Signature of employer/plan sponsor/DFE	Date	Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form **5500** (2008)
v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
SAME

3b Administrator's EIN
3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
a Sponsor's name
b EIN
c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address		**b** EIN 13-1577780
SCHULTHEIS & PANETTIERI, LLP 210 MARCUS BOULEVARD HAUPPAUGE NY 11788-3740		**c** Telephone no. 631-273-4778
6 Total number of participants at the beginning of the plan year	**6**	3995
7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a Active participants	**a**	2479
b Retired or separated participants receiving benefits	**b**	1084
c Other retired or separated participants entitled to future benefits	**c**	
d Subtotal. Add lines **7a, 7b,** and **7c**	**d**	3563
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	
f Total. Add lines **7d** and **7e**	**f**	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☐ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

b ☒ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

4A 4D 4H 4L 4Q 4U

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☐ **R** (Retirement Plan Information)
- **(2)** ☐ **T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☐ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☐ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☒ 10 **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☒ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

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Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to Public Inspection

Part I Annual Report Identification Information
For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008 , and ending June 30, 2009

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information – enter all requested information.

1a Name of plan
IBEW LOCAL 43 & ELECTRICAL CONTRACTORS PENSION FUND

1b Three-digit plan number (PN) 001
1c Effective date of plan (mo., day, yr.) July 01, 1962

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
IBEW LOCAL 43 & ELECTRICAL CONTRACTORS PENSION FUND
PO BOX 2218
SYRACUSE NY 13220-2218

2b Employer Identification Number (EIN) 16-6153389
2c Sponsor's telephone number 315-474-5729
2d Business code (see instructions) 238210

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	Date	Typed or printed name of individual signing as plan administrator
		HILLIPLLYP P .1"PEU);50^'K,C
Signature of employer/plan sponsor/DFE	Date	Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form **5500** (2008)
v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
SAME

3b Administrator's EIN 16-6153389
3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
a Sponsor's name
b EIN
c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

PARENTEBEARD I.T.C THOMAS E. RILEY
115 SOLAR ST 100
SYRACUSE N 13204

b EIN 23-2932984
c Telephone no. 154712777

6 Total number of participants at the beginning of the plan year	**6**	1601
7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a Active participants	**a**	850
b Retired or separated participants receiving benefits	**b**	478
c Other retired or separated participants entitled to future benefits	**c**	250
d Subtotal. Add lines **7a, 7b,** and **7c**	**d**	1578
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	86
f Total. Add lines **7d** and **7e**	**f**	1664
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	14
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	11

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☒ **R** (Retirement Plan Information)
- **(2)** ☐ 0T (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☒ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☒ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☐ 0 **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☒ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

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Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to Public Inspection

Part I Annual Report Identification Information
For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008 , and ending June 30, 2009

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☐

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information – enter all requested information.

1a Name of plan
IBEW LOCAL 43 AND ELECTRICAL CONTRACTORS WELFARE F UND

1b Three-digit plan number (PN) 501

1c Effective date of plan (mo., day, yr.)
February 01, 1959

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
IBEW LOCAL 43 & ELECTRICAL CONTRACT ORS WELFARE FUND
PO BOX 2218
SLKACUSE NY 13220-2218

2b Employer Identification Number (EIN)
15-6025163

2c Sponsor's telephone number
315-474-5729

2d Business code (see instructions)
238210

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

(^TW,

Signature of plan administrator | Date | Typed or printed name of individual signing as plan administrator

Signature of employer/plan sponsor/DFE | Date | Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.
v11.3
Form **5500** (2008)

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
SA14M

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

PARRNTEBEAFT) LLC THOMAS E. RILEY
115 SOT-AR SMEET 100
S'YKACUSE M 13204

b EIN 23-2932984
c Telephone no. 154712777

6 Total number of participants at the beginning of the plan year	**6**	1180
7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a Active participants	**a**	874
b Retired or separated participants receiving benefits	**b**	281
c Other retired or separated participants entitled to future benefits	**c**	
d Subtotal. Add lines **7a, 7b,** and **7c**	**d**	1155
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	
f Total. Add lines **7d** and **7e**	**f**	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☐ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

b ☒ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☐ **R** (Retirement Plan Information)
- **(2)** ☐ **T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☐ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☐ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☒ **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☒ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	**Annual Return/Report of Employee Benefit Plan** **This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).** **Complete all entries in accordance with the instructions to the Form 5500.**	Official Use Only OMB Nos. 1210 - 0110 1210 - 0089 **2008** **This Form is Open to Public Inspection**

Part I Annual Report Identification Information
For the calendar plan year 2008 or fiscal plan year beginning June 01, 2008 , and ending May 31, 2009

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information – enter all requested information.

1a Name of plan
IBEW LOCAL 241 WELFARE BENEFITS PLAN

1b Three-digit plan number (PN) 501

1c Effective date of plan (mo., day, yr.) January 01, 1960

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
IBEW LOCAL 241
701 W. STATE STREET
ITHACA NY 14850-3309

2b Employer Identification Number (EIN) 15-0347948

2c Sponsor's telephone number 607-272-2809

2d Business code (see instructions) 238210

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	Date	Typed or printed name of individual signing as plan administrator
Signature of employer/plan sponsor/DFE	Date	Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form **5500** (2008)
v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
SA14IE

3b Administrator's EIN 15-0347948

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

CDT.14 & COMPANY CPAR, LLP PA!RXIC'K JORNAN
401 E STATE ST SITE 5DO
ITHARA 14850

b EIN 16-1171627
c Telephone no. 607-272-4444

6 Total number of participants at the beginning of the plan year	**6**	166
7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a Active participants	**a**	200
b Retired or separated participants receiving benefits	**b**	
c Other retired or separated participants entitled to future benefits	**c**	
d Subtotal. Add lines **7a, 7b,** and **7c**	**d**	200
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	
f Total. Add lines **7d** and **7e**	**f**	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☐ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

b ☒ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

4A 4B 4D 4E 4L

9a Plan funding arrangement (check all that apply)
- (1) ☐ Insurance
- (2) ☐ Section 412(e)(3) insurance contracts
- (3) ☐ Trust
- (4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- (1) ☐ Insurance
- (2) ☐ Section 412(e)(3) insurance contracts
- (3) ☐ Trust
- (4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- (1) ☐ **R** (Retirement Plan Information)
- (2) ☐ 0**T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- (3) ☐ **B** (Actuarial Information)
- (4) ☐ **E** (ESOP Annual Information)
- (5) ☐ **SSA** (Separated Vested participant Information)

b Financial Schedules
- (1) ☒ **H** (Financial Information)
- (2) ☐ **I** (Financial Information – Small Plan)
- (3) ☒ 0 **A** (Insurance Information)
- (4) ☒ **C** (Service Provider Information)
- (5) ☐ **D** (DFE/Participating Plan Information)
- (6) ☐ **G** (Financial Transaction Schedules)

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Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to Public Inspection

Part I Annual Report Identification Information
For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008 , and ending June 30, 2009

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☐

Part II Basic Plan Information – enter all requested information.

1a Name of plan
I.B.E.W. LOCAL 910 HEALTH & WELFARE FUND

1b Three-digit plan number (PN) 501
1c Effective date of plan (mo., day, yr.) January 01, 1966

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
I.B.E.W. LOCAL 910 HEALTH & WELFARE FUND
25001 WATER STREET
WATERTOWN NY 13601-2145

2b Employer Identification Number (EIN) 16-6053626
2c Sponsor's telephone number 315-782-5941
2d Business code (see instructions) 561110

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	Date	JAN F LLIC- Typed or printed name of individual signing as plan administrator
Signature of employer/plan sponsor/DFE	Date	JDME^ 14 JX),-AKR.-15 Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form **5500** (2008)
v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
TRUSTEES OF THE I.B.E.W. LOCAL 910 HEALTH & WELFARE FUND
25001 WATER STREET
WATERTOWN NY 13601-2145

3b Administrator's EIN 16-6053626
3c Administrator's telephone number 315-782-5941

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
b EIN
c PN

a Sponsor's name

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address **b** EIN

c Telephone no.

6 Total number of participants at the beginning of the plan year	**6**	512
7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a Active participants	**a**	539
b Retired or separated participants receiving benefits	**b**	69
c Other retired or separated participants entitled to future benefits	**c**	
d Subtotal. Add lines **7a, 7b,** and **7c**	**d**	608
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	
f Total. Add lines **7d** and **7e**	**f**	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☐ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

b ☒ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

4U

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☐ **R** (Retirement Plan Information)
- **(2)** ☐ **T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☐ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☐ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☒ 3 **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☐ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

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Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to Public Inspection

Part I Annual Report Identification Information
For the calendar plan year 2008 or fiscal plan year beginning January 01, 2008 , and ending December 31, 2008

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information – enter all requested information.

1a Name of plan
LABORERS LOCAL 103 ANNUITY FUND

1b Three-digit plan number (PN) 002

1c Effective date of plan (mo., day, yr.)
June 01, 2002

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
TRUSTEES OF LABORERS LOCAL 103 ANNUITY FUND
P.O. BOX 571
GENEVA NY 14456-0571

2b Employer Identification Number (EIN)
01-6214544

2c Sponsor's telephone number
315-539-4220

2d Business code (see instructions)
525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	Date	UNION TRUSTEE Typed or printed name of individual signing as plan administrator
Signature of employer/plan sponsor/DFE	Date	MANAGEMENT TRUSTEE Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.
v11.3
Form **5500** (2008)

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
SAIME

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address **b** EIN

c Telephone no.

6	Total number of participants at the beginning of the plan year	**6**	166
7	Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a	Active participants	**a**	159
b	Retired or separated participants receiving benefits	**b**	
c	Other retired or separated participants entitled to future benefits	**c**	
d	Subtotal. Add lines **7a, 7b,** and **7c**	**d**	159
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	
f	Total. Add lines **7d** and **7e**	**f**	159
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	159
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i	If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

2E

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☐ **R** (Retirement Plan Information)
- **(2)** ☐ 0T (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☐ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☐ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☐ 0 **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☒ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

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Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to Public Inspection

Part I Annual Report Identification Information
For the calendar plan year 2008 or fiscal plan year beginning January 01, 2008 , and ending December 31, 2008

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information – enter all requested information.

1a Name of plan
LABORERS LOCAL 103 WELFARE FUND

1b Three-digit plan number (PN) 501

1c Effective date of plan (mo., day, yr.)
October 15, 1954

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
TRUSTEES OF LABORERS LOCAL 103 WELFARE FUND
P.O. BOX 571
GENEVA NY 14456-0571

2b Employer Identification Number (EIN)
16-0778602

2c Sponsor's telephone number
315-539-4220

2d Business code (see instructions)
525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	Date	UNION TRUSTEE Typed or printed name of individual signing as plan administrator
Signature of employer/plan sponsor/DFE	Date	MANAGEMENT TRUSTEE Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.
v11.3
Form **5500** (2008)

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
SAIMP

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address **b** EIN

c Telephone no.

6	Total number of participants at the beginning of the plan year	**6**	169
7	Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a	Active participants	**a**	82
b	Retired or separated participants receiving benefits	**b**	8
c	Other retired or separated participants entitled to future benefits	**c**	57
d	Subtotal. Add lines **7a, 7b,** and **7c**	**d**	147
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	
f	Total. Add lines **7d** and **7e**	**f**	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i	If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☐ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

b ☒ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

4A 4C 4D 4E 4L 4Q

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☐ **R** (Retirement Plan Information)
- **(2)** ☐ **T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☐ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☐ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☐ **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☒ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

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Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to Public Inspection

Part I Annual Report Identification Information
For the calendar plan year 2008 or fiscal plan year beginning January 01, 2008 , and ending December 31, 2008

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information – enter all requested information.

1a Name of plan
OSWEGO LABORERS LOCAL 214 RETIREMENT PLAN

1b Three-digit plan number (PN) 004
1c Effective date of plan (mo., day, yr.)

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
BOARD OF TRUSTEES, LABORERS LOCAL 214 RETIREMENT PLAN
23 MTTCHET.T. STREET
NWMGO NY 13126

2b Employer Identification Number (EIN)
16-0876163
2c Sponsor's telephone number
315-343-1666
2d Business code (see instructions)
525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

	10/11/2109	CINVY RA.C;TAT.T)O
Signature of plan administrator	Date	Typed or printed name of individual signing as plan administrator
		)SWEGO T.AF30RKKS LORAY, 214 RETIRK
Signature of employer/plan sponsor/DFE	Date	Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.
v11.3
Form **5500** (2008)

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
SA14IE

3b Administrator's EIN
16-0876163
3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
a Sponsor's name
b EIN
c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address		**b** EIN 23-3060766
BRAPN MILLKK COMPANY LLP TH014AS E RIT.JSY 115 SOT-AR S'RK(RET 100 S)RMACUSE 13204		**c** Telephone no. 315-471-2777
6 Total number of participants at the beginning of the plan year	**6**	504
7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a Active participants	**a**	103
b Retired or separated participants receiving benefits	**b**	269
c Other retired or separated participants entitled to future benefits	**c**	96
d Subtotal. Add lines **7a, 7b,** and **7c**	**d**	468
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	36
f Total. Add lines **7d** and **7e**	**f**	504
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	11

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☐ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

1B 1G

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☒ **R** (Retirement Plan Information)
- **(2)** ☐ **T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☒ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☒ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☐ **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☒ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

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Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to Public Inspection

Part I Annual Report Identification Information
For the calendar plan year 2008 or fiscal plan year beginning January 01, 2008 , and ending December 31, 2008

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☐

Part II Basic Plan Information – enter all requested information.

1a Name of plan
PLUMBERS PIPE FITTERS & APPRENTICES LOCAL 112 HEALTH PLAN

1b Three-digit plan number (PN) 501
1c Effective date of plan (mo., day, yr.) October 01, 1960

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
TRUSTEES OF PLUMBERS PIPE FITTERS & APPRENTICES LOCAL 112 HEALTH FUND
11 GRISWOLD STREET
BINGHAMTON NY 13904-1511

2b Employer Identification Number (EIN) 16-6053348
2c Sponsor's telephone number 607-722-1883
2d Business code (see instructions) 238220

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	Date	UNION TRUSTEE Typed or printed name of individual signing as plan administrator
Signature of employer/plan sponsor/DFE	Date	EMPLOYER TRUSTEE Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form **5500** (2008)
v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
SAME

3b Administrator's EIN
3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
a Sponsor's name
b EIN
c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address **b** EIN

c Telephone no.

6	Total number of participants at the beginning of the plan year	**6**	686
7	Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a	Active participants	**a**	413
b	Retired or separated participants receiving benefits	**b**	229
c	Other retired or separated participants entitled to future benefits	**c**	
d	Subtotal. Add lines **7a, 7b,** and **7c**	**d**	642
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	
f	Total. Add lines **7d** and **7e**	**f**	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i	If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☐ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

b ☒ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

4A 4E 4L

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☐ **R** (Retirement Plan Information)
- **(2)** ☐ **T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☐ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☐ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☒ **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☐ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

Form 5500 Department of the Treasury Internal Revenue Service	**Annual Return/Report of Employee Benefit Plan**	Official Use Only OMB Nos. 1210 - 0110 1210 - 0089
Department of Labor Employee Benefits Security Administration	**This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).** **Complete all entries in accordance with the instructions to the Form 5500.**	**2008**
Pension Benefit Guaranty Corporation		**This Form is Open to Public Inspection**

Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008 , and ending June 30, 2009

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information – enter all requested information.

1a Name of plan

ROOFERS LOCAL 195 ANNUITY FUND

1b Three-digit plan number (PN) 002

1c Effective date of plan (mo., day, yr.)
July 01, 1449

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)

ROOFERS LOCAL 195 ANNUITY FUND
6200 STATE ROUTE 31
CICERO NY 13039-8804

2b Employer Identification Number (EIN)
14-1721374

2c Sponsor's telephone number
315-699-1388

2d Business code (see instructions)
525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

RL (C/ ^Q NO

Signature of plan administrator	Date	Typed or printed name of individual signing as plan administrator
Signature of employer/plan sponsor/DFE	Date	Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form **5500** (2008)
v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")

SAME

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

PARENTEBRARD LLC THOMAS E. RILEY
115 SOT-AR SRXEET 100
SYMACLISE 13204

b EIN 23-2932984
c Telephone no. 154712777

6 Total number of participants at the beginning of the plan year	**6**	327
7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a Active participants	**a**	228
b Retired or separated participants receiving benefits	**b**	17
c Other retired or separated participants entitled to future benefits	**c**	113
d Subtotal. Add lines **7a, 7b,** and **7c**	**d**	358
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	2
f Total. Add lines **7d** and **7e**	**f**	360
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	13
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	16

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☐ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☐ **R** (Retirement Plan Information)
- **(2)** ☐ **T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☐ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☒ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☒ **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☒ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
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1210 - 0089
2008
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Part I Annual Report Identification Information
For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008 , and ending June 30, 2009

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information – enter all requested information.

1a Name of plan
ROOFERS LOCAL 195 HEALTH & ACCIDENT FUND

1b Three-digit plan number (PN) 501

1c Effective date of plan (mo., day, yr.)
July 01, 1972

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
ROOFERS LOCAL 195 HEALTH & ACCIDENT FUND
6200 STATE ROUTE 31
CICERO NY 13039-8804

2b Employer Identification Number (EIN)
16-6148181

2c Sponsor's telephone number
315-699-1388

2d Business code (see instructions)
525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	Date	Typed or printed name of individual signing as plan administrator
Signature of employer/plan sponsor/DFE	Date	Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form **5500** (2008)
v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
SAME

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

PARENTEBEARD LLC THOMAS E. RILEY
115 SOLAR STREET 100
SYRACUSE 13204

b EIN 23-2932984
c Telephone no. 315-471-2777

6 Total number of participants at the beginning of the plan year	**6**	184
7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a Active participants	**a**	210
b Retired or separated participants receiving benefits	**b**	
c Other retired or separated participants entitled to future benefits	**c**	
d Subtotal. Add lines **7a, 7b,** and **7c**	**d**	210
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	
f Total. Add lines **7d** and **7e**	**f**	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☐ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

4A 4B

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☐ **R** (Retirement Plan Information)
- **(2)** ☐ **T** (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

- **(3)** ☐ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☐ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☒ **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☒ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

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Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to Public Inspection

Part I Annual Report Identification Information
For the calendar plan year 2008 or fiscal plan year beginning January 01, 2008 , and ending December 31, 2008

A This return/report is for:
(1) ☐ a multiemployer plan;
(2) ☒ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☐

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☐

Part II Basic Plan Information – enter all requested information.

1a Name of plan
SYRACUSE BUILDERS EXCHANGE, INC. / CEA PENSION PLAN

1b Three-digit plan number (PN) 001
1c Effective date of plan (mo., day, yr.) January 01, 1982

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
SYRACUSE BUILDERS EXCHANGE, INC.
6563 RIDINGS ROAD
SYRACUSE NY 13206-1202

2b Employer Identification Number (EIN) 15-0464360
2c Sponsor's telephone number 315-437-9936
2d Business code (see instructions) 238900

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	Date	EARL N. HALL Typed or printed name of individual signing as plan administrator
Signature of employer/plan sponsor/DFE	Date	EARL N. HALL Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form **5500** (2008)
v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
SAME

3b Administrator's EIN
3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
a Sponsor's name
b EIN
c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address **b** EIN

c Telephone no.

6	Total number of participants at the beginning of the plan year	**6**	14
7	Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a	Active participants	**a**	15
b	Retired or separated participants receiving benefits	**b**	
c	Other retired or separated participants entitled to future benefits	**c**	
d	Subtotal. Add lines **7a, 7b,** and **7c**	**d**	15
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	
f	Total. Add lines **7d** and **7e**	**f**	15
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	15
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i	If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

2E 2J

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☒ **R** (Retirement Plan Information)
- **(2)** ☐ **0T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☐ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☐ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☐ **H** (Financial Information)
- **(2)** ☒ **I** (Financial Information – Small Plan)
- **(3)** ☐ **0 A** (Insurance Information)
- **(4)** ☐ **C** (Service Provider Information)
- **(5)** ☐ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2007
This Form is Open to Public Inspection

Part I Annual Report Identification Information
For the calendar plan year 2007 or fiscal plan year beginning November 01, 2007 , and ending October 31, 2008

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☐

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information – enter all requested information.

1a Name of plan
SERVICE EMPLOYEES BENEFIT FUND

1b Three-digit plan number (PN) 501
1c Effective date of plan (mo., day, yr.) January 01, 1965

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
SERVICE EMPLOYEES BENEFIT FUND
1153 WEST FAYETTE STREET
SYRACUSE NY 13204-2741

2b Employer Identification Number (EIN) 15-0613682
2c Sponsor's telephone number 315-424-1754
2d Business code (see instructions) 525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	Date	TAMMY A. MCMANUS Typed or printed name of individual signing as plan administrator
Signature of employer/plan sponsor/DFE	Date	JEREMIAH DENNIS, JR. Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form **5500** (2007)
v2.3

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
SAME

3b Administrator's EIN
3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
a Sponsor's name
b EIN
c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address **b** EIN

c Telephone no.

6	Total number of participants at the beginning of the plan year	**6**	12518
7	Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a	Active participants	**a**	12336
b	Retired or separated participants receiving benefits	**b**	96
c	Other retired or separated participants entitled to future benefits	**c**	
d	Subtotal. Add lines **7a, 7b,** and **7c**	**d**	12432
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	
f	Total. Add lines **7d** and **7e**	**f**	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i	If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☐ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

b ☒ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

4A 4D 4E 4F 4L

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(i) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(i) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☐ **R** (Retirement Plan Information)
- **(2)** ☐ **0T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☐ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☐ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☐ **0 A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☐ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

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Form 5500	**Annual Return/Report of Employee Benefit Plan**	Official Use Only
Department of the Treasury Internal Revenue Service	**This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).** **Complete all entries in accordance with the instructions to the Form 5500.**	OMB Nos. 1210 - 0110 1210 - 0089
Department of Labor Employee Benefits Security Administration		**2008**
Pension Benefit Guaranty Corporation		**This Form is Open to Public Inspection**

Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning January 01, 2008 , and ending December 31, 2008

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information – enter all requested information.

1a Name of plan

SERVICE EMPLOYEES PENSION FD OF UPSTATE NEW YORK

1b Three-digit plan number (PN) 001

1c Effective date of plan (mo., day, yr.) April 29, 1965

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)

SERVICE EMPLOYEES PENSION FUND OF UPSTATE NEW YORK
BETH BARRETT, FUND MANAGER
PO BOX 1240
SYRACUSE NY 13201-1240

2b Employer Identification Number (EIN) 16-0908576

2c Sponsor's telephone number 315-424-1754

2d Business code (see instructions) 812990

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

-EL-1W RQOZC--^^

Signature of plan administrator	Date	Typed or printed name of individual signing as plan administrator
Signature of employer/plan sponsor/DFE	Date	Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form **5500** (2008)
v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")

SERVICE EMPL PENSION FUND OF UPSTATE NEW YORK
BETH BARRETT, FUND MANAGER
PO BOX 1240
SYRACUSE NY 13201-1240

3b Administrator's EIN 16-0908576

3c Administrator's telephone number 315-424-1754

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

c PN

a Sponsor's name

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address **b** EIN

ROBERT E. KILFOYLE, CPA
109 S WARREN ST STE 1403
SYRACUSE NY 13202-4711

c Telephone no. 315-422-4900

6 Total number of participants at the beginning of the plan year	**6**	7493
7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a Active participants	**a**	4942
b Retired or separated participants receiving benefits	**b**	1065
c Other retired or separated participants entitled to future benefits	**c**	1791
d Subtotal. Add lines **7a, 7b,** and **7c**	**d**	7798
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	102
f Total. Add lines **7d** and **7e**	**f**	7900
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	184

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

1B

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules
- **(1)** ☒ **R** (Retirement Plan Information)
- **(2)** ☐ **T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
- **(3)** ☒ **B** (Actuarial Information)
- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☒ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☐ **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☒ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)

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Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to Public Inspection

Part I Annual Report Identification Information
For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008 , and ending June 30, 2009

A This return/report is for:
(1) ☒ a multiemployer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan);
(3) ☐ a multiple-employer plan;
(4) ☐ a DFE (specify)

B This return/report is:
(1) ☐ the first return/report filed for the plan;
(2) ☐ the amended return/report;
(3) ☐ the final return/report filed for the plan;
(4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information – enter all requested information.

1a Name of plan
LOCAL 73 RETIREMENT FUND

1b Three-digit plan number (PN) 001
1c Effective date of plan (mo., day, yr.) July 01, 1419

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
LOCAL 73 RETIREMENT FUND
705 RAST SENECA STMEET, PO BOX 911
OSWJ5GO NY 13126-0911

2b Employer Identification Number (EIN) 15-6016577
2c Sponsor's telephone number 315-343-1808
2d Business code (see instructions) 525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator	Date	JAIAKS GAFFNEY Typed or printed name of individual signing as plan administrator
		LORAT. 73 RETIR1914KNT FUNI) Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable
Signature of employer/plan sponsor/DFE	Date	

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form **5500** (2008)
v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter"Same")
JAMES GAFKNEY
705 EAST SENECA STREET PO BOX 911
OSWZGO NY 13126-0911

3b Administrator's EIN 22-3739111
3c Administrator's telephone number 315-343-1808

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
b EIN
c PN

a Sponsor's name

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

PARENTEBEARN LLC THOMAS E. RILEY
115 SOLAR STREET 100
SYRACUSE 13204

b EIN 23-2932984
c Telephone no. 315-471-2777

6 Total number of participants at the beginning of the plan year	**6**	860
7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**)		
a Active participants	**a**	339
b Retired or separated participants receiving benefits	**b**	363
c Other retired or separated participants entitled to future benefits	**c**	83
d Subtotal. Add lines **7a, 7b,** and **7c**	**d**	785
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**e**	83
f Total. Add lines **7d** and **7e**	**f**	868
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**g**	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**h**	1
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	**i**	1

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

1B

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9a Plan funding arrangement (check all that apply)
- **(1)** ☐ Insurance
- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☐ General assets of the sponsor

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- **(2)** ☐ Section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
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- **(2)** ☐ **T** (Qualified Pension Plan Coverage Information)

  If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year
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- **(4)** ☐ **E** (ESOP Annual Information)
- **(5)** ☒ **SSA** (Separated Vested participant Information)

b Financial Schedules
- **(1)** ☒ **H** (Financial Information)
- **(2)** ☐ **I** (Financial Information – Small Plan)
- **(3)** ☒ 1 **A** (Insurance Information)
- **(4)** ☒ **C** (Service Provider Information)
- **(5)** ☒ **D** (DFE/Participating Plan Information)
- **(6)** ☐ **G** (Financial Transaction Schedules)